Mental Health Plan – Department of Mental Health
REQUEST TO CHANGE PROVIDER

MONTHLY LOG

This log is to be maintained by each Program Manager for the program(s) for which he/she is responsible. A completed entry shall be made for each "Request for Change of Provider" form received during each month. A copy shall be sent to the Beneficiary Services Program in the Patients' Rights Office by the tenth (10^{th}) working day following the month for which the log is completed.

Month_____ Year_____

Check here if no requests were received during this month [ ]

DATE RECEIVED	DATE OF REQUEST	CONSUMER NAME	CURRENT PROVIDER	NEW PROVIDER	REASON FOR REQUEST (If Pt. willing to state)	REASON WHY REQUEST NOT GRANTED

6/6/02 RTCP

_____ _____ _____

REPORTING UNIT PROGRAM MANAGER DATE

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled	**Name** _____**MIS#**_____ **Facility/Practitioner:**_____ **Los Angeles County – Department of Mental Health**